Volume 2 Summer 2005

NEBRASKA DEPARTMENT OF INSURANCE

Dave Heineman
Governor

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Director

Inside:

Health Care Prompt Payment Act Passed By Legislature

The 2005 session of the Nebraska Legislature passed LB 389, the Health Care Prompt Payment Act, codified at Neb. Rev.Stat. §§44-8001 through 44-8010, setting standards for the prompt payment of claims to health care providers by insurers. Under the act, insurers must pay interest on clean claims that are not paid within the time limits set forth under the law, unless the insurer has filed a valid "prompt payment act compliance statement" with the Nebraska Department of Insurance by December 1st of each year.

Insurers that choose to file a prompt payment compliance statement are advised that in the event of an investigation of insurer claims settlement practices, either as part of a formal market conduct examination, or as part of an investigation conducted pursuant to the act, the Department will look to verify the prompt payment act compliance statement is valid.

Several insurers have asked the Department for guidance about the nature and contents of the prompt payment act compliance statement. A company bulletin, CB-108, was issued on July 15, 2005, to respond to that request, by providing an example statement that will comply with the requirements of the Act. The statement set forth in the bulletin is an example of a valid prompt payment act compliance statement. The example is a non-exclusive illustration that insurers may follow to file a valid prompt payment act compliance statement.

A copy of CB-108 can be obtained from the Department's web site at www.doi.ne.gov.

PROPERTY & CASUALTY DIVISION

Online Rating Interface Available Through AIPSO

AIPSO now has an online rating interface for certain private passenger risks who are applying for coverage through the assigned risk plan in Nebraska along with several other states.

Automobile Insurance Plans Service Office (AIPSO) now has an online rating interface for certain private passenger risks who are applying for coverage through the assigned risk plan in Nebraska along with several other states. Producers can complete and submit the application through the Internet to the Plan. The electronic version of the application can be printed, signed, and mailed to the Plan along with the appropriate premium and any supporting documents that may be required.

Because there is a fairly extensive list of situations that do not qualify for this online rating process, we suggest you check with AIPSO at www.apiso.com.

The total policy premium is an estimated premium that is subject to change pending verification of underwriting information, such as driving history and vehicle use. There is a fairly extensive list of situations that do not qualify for this online rating process. If this is something being considered, we suggest that you check with AIPSO at *www.apiso.com.*

Consent-to-Rate Filings

Consent-to-rate filings on most lines of insurance will be accepted; however, the consent-to-rate has to be an increase in the rate currently on file.

We will accept consent-to-rate filings on most lines of insurance; however, the consent-to-rate has to be an increase in the rate currently on file with the Department.

Any requirement for the signature of the insured acknowledging that the filing is in excess of the rate on file with the department is only required for that which exceeds the 40% debit.

There appears to be some confusion regarding the use of this process as we have seen some recently attempting to use to reduce a Workers' Compensation premium. Please keep in mind that our current Rate and Form Act allows a 40% rating flexibility on most commercial lines, **with one exception being Workers' Compensation**. Any requirement for the signature of the insured acknowledging that the filing is in excess of the rate on file with the department is only required for that which exceeds the 40% debit.

Legislation passed this session, which will be effective September 4, 2005, allows a 40% rating flexibility on Workers' Compensation as well.

MARKET CONDUCT DIVISION

Coverage for Newly Born Children

Insurers are required to provide benefits on all covered health services for newly born children for the first thirty-one days from the moment of their birth.

We would like to remind Health Maintenance Organizations and all insurers who issue individual and group policies of sickness and accident coverage on an expense-incurred basis of their responsibilities when a claim is received on the newly born child of an insured or subscriber. Neb.Rev.Stat. §44-710.19 (1) requires insurers to provide benefits on all covered health services for newly born children from the moment of their birth. This coverage is to continue for the first thirty-one days.

An insurer cannot deny applicable benefits because the newly born child is not a covered dependent under the policy or contract at the time the covered health services were incurred, if those covered health services were incurred during the first 31 days of the newly born child's date of birth.

Coverage is automatic for the first thirty-one days from the moment of birth of the newly born child of an insured or subscriber whether the policy or contract is for the insured/subscriber only, insured/subscriber and spouse or family coverage. The insurer cannot deny applicable benefits because the newly born child is not a covered dependent under the policy or contract at the time the covered health services were incurred, if those covered health services were incurred during the first 31 days of the newly born child's date of birth. The company may request verification from the insured or subscriber as to whether or not the newly born child is covered under another policy or contract, if the policy has a coordination of benefits provision.

Neb.Rev.Stat. §44-710.19 (3) allows the insurer to require notification of the newly born child and the payment of the required premium or fees during the first thirty-one days from the date of birth. This notification and payment requirement is for coverage to continue beyond the first thirty-one days. An insurer may not require that notification be made or the child added to the policy or contract prior to the newly born child's date of birth.

Coverage on the newly born child will cease on the thirty-second day, if the insurer does not receive notification and/or the required payment of premium or fees during the first thirty-one days to continue coverage after the thirty-first day.

Coverage on the newly born child will cease on the thirty-second day, if the insurer does not receive notification and/or the required payment of premium or fees during the first thirty-one days to continue coverage after the thirty-first day. When notification and/or the required payment of premium or fees is received after the first thirty-one days and there will be a lapse in coverage, the insurer should follow its policies and procedures in determining the new effective date of coverage for the newly

The effective date of coverage for the newly born child of an insured or subscriber is their date of birth until the thirty-one-day period has expired.

born child. Remember, the effective date of coverage for the newly born child of an insured or subscriber is their date of birth until the thirty-one-day period has expired. If notification and/or the required payment of premium or fees have been received during the first thirty-one days and coverage will be continuous with no lapse in coverage, the newly born child's date of birth will remain as the effective date of coverage.

When a claim is received during the first thirty-one days from the newly born child's date of birth, the insurer cannot stipulate that applicable benefits will only be provided after the newly born child has been enrolled and added to the policy or contract.

When a claim is received for covered health services incurred during the first thirty-one days from the newly born child's date of birth, the insurer cannot stipulate that applicable benefits will only be provided after the newly born child has been enrolled and added to the policy or contract.

Also, if the insurer receives a claim more than thirty-one days from the newly born child's date of birth for covered health services that were incurred during the first thirty-one days from the newly born child's date of birth, and the insured's records indicate that the newly born child's effective date has been changed because there was a lapse in coverage, the insurer must ensure that the claim is not denied as charges incurred prior to the effective date of the patient's coverage.

*The insurer **must** provide all applicable benefits for any covered health services that are incurred during the first thirty-one days from the newly born child's date of birth.*

The insurer ***must*** provide all applicable benefits for any covered health services that are incurred during the first thirty-one days from the newly born child's date of birth.

PRODUCER LICENSING DIVISION

Producer's License Needed for Sale of Insurance Products through Funeral Homes

A funeral home's involvement in the sale, solicitation, or negotiation of insurance, even though the funeral home does not hold a current insurance producer's license, is in violation of the law.

It has recently come to the attention of the Nebraska Department of Insurance that some funeral homes may be involved in the sale, solicitation or negotiation of insurance even though the funeral home does not hold a current insurance producer's license from the Nebraska Department of Insurance. If so, it is in violation of the law and the sale, solicitation and/or negotiation of insurance needs to be stopped and an insurance producer's license must be obtained before resuming such activities.

An individual "attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company," is soliciting insurance under Neb.Rev.Stat. §44-4049(15).

To negotiate insurance means, "the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, if the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers," under Neb. Rev.Stat. §44-4049(12).

Selling insurance means, "to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company," under Neb.Rev.Stat. §44-4049(15).

If an individual is, "attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company," then that individual is soliciting insurance under Neb.Rev.Stat. §44-4049(15).

If a funeral home suggests that a person fund their pre-arranged funeral costs..., or advises..., or accepts an application for insurance..., then both the individual and the business entity need to hold insurance producer licenses.

If anyone in a funeral home suggests that a person fund their pre-arranged funeral costs with an insurance policy from a particular company, or advises a customer or prospective customer about a particular insurance policy's substantive benefits, or accepts an application for insurance that will be sent in to an insurance company, other business entity or brokerage firm, then both the individual and the business entity need to hold insurance producer licenses.

Applications can be obtained through the Department's website at *www.doi.ne.gov*, or by calling the Producer Licensing Division at (402) 471-4913.

FRAUD DIVISION

New Investigator Joins Division

In June, Investigator Steve Eppens joined the Fraud Unit. Steve comes to us with prior investigative experience working for the Lancaster County Sheriff's Office, Investigation Division.

Fraudulent Billing Practices in Auto Glass Repair

The Insurance Fraud Prevention Division (IFPD) recently forwarded a case to the Lancaster County Attorney's Office for prosecution. This case involved a auto glass vendor who is alleged to have submitted fraudulent statements in violation of the Insurance Fraud Act, §28-631 (1): "A person or entity commits a fraudulent insurance act if he or she: (a): Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or any agent of an insurer, any statement as part of, in support of, or in denial of a claim for payment or other benefit pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim."

The vendor in this case is accused of defrauding six different insurance companies of thousands of dollars in claims over a two-year period. Unfortunately this problem is not unique and our division has investigated cases similar in nature.

IFPD urges insurers to review their individual company procedures in the "handling" of claims of this nature. Safeguards can be put into place, which would in effect note "red flags" of potential abuse. Both the insurers and the insured will benefit from these fraud prevention techniques. We urge your continued cooperation to send referrals if you suspect insurance fraud as we, in a joint effort, aggressively combat insurance fraud.

EXAMINATION DIVISION

Pre-Need Exams Completed During Second Quarter, 2005

Brand-Wilson Funeral Home, Inc.
Harman-Wright Mortuary, Inc.

Financial Examinations Completed During Second Quarter, 2005

American Insurance Company (The)
Central States Indemnity Co. of Omaha
CSI Life Insurance Company
Empire Fire & Marine Insurance Company
Fireman's Fund Insurance Company of Nebraska
Lincoln Benefit Life Company
Mutual of Omaha Insurance Company
Surety Life Insurance Company
Union Insurance Company
United of Omaha Life Insurance Company
United World Life Insurance Company

Financial examination reports become public documents once they have been placed on official file by the Department. Copies may be obtained from the Department at the cost of $.50 per page.

LEGAL DIVISION

Supreme Court Cases

Olson v. Le Mars Mutual Insurance Co., 269 Neb. 800 (May 13, 2005)

Plaintiff Norris Olson owned a grain storage building that was damaged by hail; the cost to repair the damage was estimated to be $95,040. Immediately before the damage, the building had a market value of approximately $200,000. After the damage occurred, Olson sold the building for $100,000. Le Mars Mutual Insurance Co. had issued an insurance policy to cover the building. The policy stated that when Le Mars had the duty to indemnify Olson, Le Mars could choose between the lesser of actual cash value (ACV) of the building and the ACV cost to repair/replace the damaged property.

Le Mars elected to pay the cost to repair the damage. However, Le Mars adjusted the damage claim for depreciation. The building was approximately 40 years old, and estimated to have an expected useful life of 100 years. Olson rejected the offer of $57,365.60 ($95,040 damage, 40% depreciation, $500 deductible) and filed a claim against the insurer for the full $94,540 ($95,040 damage, $500 deductible).

The issue in this case stems from the use of "ACV". The Nebraska Supreme Court agreed that use of "ACV" would enable the insurer to deduct depreciation on the occasions it chose to indemnify for a full loss rather than for repair costs. However, the Court rejected the notion that, on the occasions the insurer elects to repair rather than replace, the insured would receive a windfall absent depreciation, stating "[r]ecovery of the full repair costs without a depreciation deduction [would] restore the value of the insured property that existed immediately prior to the loss, but will not enhance that value." The Court then concluded that, unless the policy specifically allowed for depreciation, "an insurer may not deduct depreciation from the cost of repairing partial damage to insured property where the ACV of the property, as repaired, does not exceed its ACV at the time of the loss."

The Court then reversed the trial court, which had adjusted the award up to $99,500 (to reflect the loss of fair market value to the building less the $500 deductible), and reduced the award to $94,540. "Le Mars' liability under its policy is limited to the repair cost of $95,040 less the insured's $500 deductible."

Blue Cross and Blue Shield of Nebraska, Inc. v. Dailey, 268 Neb. 733 (Oct. 22, 2004)

In February of 1999, a Union Pacific (UP) locomotive barreled across the Nebraska prairie. As it passed through Lincoln County, friction fashioned by the convention of the train wheels and the rails produced sparks. Some of the sparks came to rest on the drought stricken grasses, and soon a prairie fire roared across the winter landscape. Lemoyne Dailey hastened to extinguish the flames; unfortunately, in attempting to quell the swelling inferno from destroying more pristine grassland, he himself was engulfed in the blaze. He suffered both second- and third-degree burns, and, because of his severe injury, was forced to reside in a hospital for several months.

Dailey and UP reached a settlement agreement, whereby UP would pay Dailey $1,225,000, as well as $10,000 a month for 10 years. However, Blue Cross and Blue Shield (BCBS), Dailey's health insurance company, claimed that under its contract with Dailey, it was entitled to subrogation and sued Daily for its contribution. Although Dailey had not yet been fully compensated for all of his losses (and consequently was not receiving a windfall by receiving full compensation from both the tort-feasor and the insurer)

BCBS claimed it was entitled to some of the money Dailey received from UP. This claim extended from a subrogation provision in the insurance contract, which allowed BCBS to recover proceeds received by Dailey up to the amount of its contribution to Dailey's medical bills, regardless of whether Dailey had been made whole.

The issue presented in this case is whether a court should enforce a policy provision that would allow an insurer to demand subrogation from an insured, even though the insured has not been fully compensated.

The Nebraska Supreme Court determined that "subrogation clauses should be construed to confirm, but not expand, the equitable subrogation rights of insurers." This supposition stems from the idea that an insured has paid the insurer to bear a risk, and that between the insurer and the insured, the insurer should shoulder the loss. "Where an insurer seeks subrogation and the insured has not been made whole through his or her recovery, equitable principles necessitate disallowing the insurer to assert its subrogation right."

Johnson v. US Fidelity and Guarantee, 269 Neb. 731 (May 6, 2005)

An auto dealer, Leon Brown, asked Gregory Johnson, a partner in a Nebraska auto dealership called Action Auto Exchange (AAE), to go to Colorado and drive back to Nebraska any automobile that Brown might buy at auction. Brown paid AAE for Johnson's services. AAE was insured by Employers Mutual Casualty Company (EMC), and Brown's dealership was insured by United States Fidelity and Guaranty Company (USF&G). Both of these policies provided, among other things, UIM coverage.

Johnson was injured by a tort-feasor in an auto accident in Colorado. The tort-feasor had two insurance carriers, both of which tendered their policy limits, $50,000 and $100,000. Johnson, who suffered monetary damages much greater than that, then sued both USF&G and EMC for the UIM coverage.

The issue in this case concerns conflicts of law. The Nebraska Supreme Court noted that it had previously held that if the action were to arise out of Tort, then Section 146 of the Restatement (Second) of Conflict of Laws governs choice of law questions in actions for uninsured or UIM benefits. That section says that in an action for personal injury, the local law of the state where the injury occurred determines the rights and liabilities of the parties. (In this case, that means Colorado law would apply.) However, if the action were to arise out of Contract, then Section 188 of that Restatement applies. That section says the rights and duties of a contract are determined by the local law of the state which has the most significant relationship to the parties. (In this case, that means Nebraska law would apply.)

The Nebraska Supreme Court determined that "[t]he right of an insured to recover benefits from his or her insurer requires a court to review the scope of the insurance contract as well as any statutes governing the contract provisions" and therefore "Johnson's action sounds in contract, not tort, even though it is tortuous conduct that triggers applicable contractual provisions." The Court determined Nebraska law applied, which would require both USF&G and EMC to tender payment for the UIM coverage.

Arbitration Provisions in Insurance Policies

The Department is receiving inquiries from companies regarding the inclusion of mandatory binding arbitration provisions in policy forms. Arbitration provisions requiring a policyholder to submit controversies arising after the issuance of the policy to binding arbitration are not consistent with the Nebraska Uniform Arbitration Act (NUAA), and will not be approved by the Department.

An insurer and a policyholder may enter into a voluntary binding arbitration agreement after an actual dispute arises. The NUAA provides that "a written agreement to submit an existing controversy to arbitration is valid, enforceable, and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract." Neb.Rev.Stat. §25-2602.01(a) (Reissue 2004). The NUAA would then confer jurisdiction on the court to enforce the arbitration agreement and enter a judgment based upon the arbitration award. See Hartman v. City of Grand Island, 265 Neb. 433, 657 N.W.2d 641 (2003).

An insurer may not include a provision in a policy form requiring policyholders to submit future disputes to arbitration. The NUAA provides that "a written contract to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable, and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract, if the provision is entered into voluntarily and willingly." Neb.Rev.Stat. §25-2602.01(b) (Reissue 2004). However, this subsection "does not apply to…any agreement concerning or relating to an insurance policy." Neb.Rev.Stat. §25-2602.01(f)(4) (Reissue 2004). Prior to the enactment of this statute, pre-dispute binding arbitration clauses were void in Nebraska as against public policy. See Millenium Solutions, Inc. v. Davis, 258 Neb. 293, 603 N.W.2d 406 (1999). Based upon this explicit insurance policy carve-out, pre-dispute binding arbitration provisions are not favored under the NUAA and are not approved for inclusion in Nebraska insurance policy forms.

Two exceptions exist to the pre-dispute carve-out under the NUAA. Pre-dispute binding arbitration provisions are valid, enforceable, and irrevocable if placed in contracts between insurance companies, including reinsurance contracts, or if placed in the bylaws of assessment associations. See Neb.Rev.Stat. §25-2602.01(e)(4) (Reissue 2004). All other mandatory binding arbitration provisions will not be approved for inclusion in Nebraska insurance policy forms.

Class-Action Fairness Act of 2005

On February 18, 2005, President Bush signed into law the Class-Action Fairness Act of 2005. This Act is designed to bring procedural reform to class action lawsuits, and applies to all actions filed after the date of enactment. The Act provides easier access to federal courts by expanding diversity jurisdiction and expanding removal rights, changes the procedure for settling class action suits in federal court, and regulates settlements involving coupons. Changes under the Act include:

- No longer requires complete diversity for federal courts to obtain jurisdiction over class actions. Diversity is now sufficient if less than two-thirds of the class members are citizens of a foreign state and none of the significant defendants are citizens of the state in which the action was filed.
- Changes the total amount in controversy threshold required for federal courts to obtain jurisdiction over class actions from $75,000 (arguably per class member) to an aggregate of all class member claims exceeding $5 million.
- Allows removal from state to federal court whenever the grounds for diversity jurisdiction arise rather than requiring diversity be achieved within one year of commencement of the suit.
- Allows removal from state to federal court "without regard to whether any defendant is a citizen of the state in which the action is brought" rather than prohibiting removal from a court in a state in which one of the defendants is a citizen.
- Allows removal from state to federal court by any single defendant rather than requiring the unanimous consent of all defendants.
- Allows for review upon appeal of a district court order remanding the case to state court.
- Requires that the court conduct a hearing and make a written finding that the settlement is fair, reasonable, and adequate for class members prior to approving a coupon settlement.
- Allows only the value of the coupons redeemed to be considered when the value of coupons is used in calculating attorney fees.
- Requires that a settlement resulting in a net monetary loss to any class member can only be approved if the court makes a written finding that non-monetary benefits to the class member substantially outweigh the monetary loss.
- Prohibits a settlement from being approved if it provides for greater payments to certain class members solely upon the basis that these class members are located in closer geographic proximity to the court.
- Requires that notice of a proposed settlement be served upon appropriate state and federal officials within ten days of filing.

The Act is intended to thwart venue shopping, and should result in most large interstate class actions moving into federal court. The heightened level of judicial scrutiny over settlements is intended to avoid excessive attorney fees and situations in which the class members receive little or no benefit from the class action.

Actions Taken Against Companies

CAUSE NO.	ALLEGATION	DISPOSITION
C-1517 ***Creative Risk Solutions*** Des Moines, IA	Multiple violations of Neb. Rev. Stat. §44-5812(1). Operated as a third-party administrator without a certificate of authority.	Consent Order $7,000 admin. fine 4/20/05
I-61 ***GenuCare, Inc.*** Hurst, TX	Violated Neb. Rev. Stat. §44-2002. Transacted unauthorized insurance business in Nebraska.	Cease and Desist Order 5/27/05

Actions Taken Against Producers

CAUSE NO.	ALLEGATION	DISPOSITION
A-1612 ***Cheri A. Uettwiller*** Papillion, NE	Violated Neb. Rev. Stat. §44-4059 (1)(b). Violated an order of the director.	Consent Order Producer license suspended until a CPA audit for the year ending 12/31/03 is received 4/20/05
A-1614 ***Holmes Murphy and Associates, Inc.*** Omaha, NE	Violated Neb. Rev. Stat. §§44-5812(1) and 44-1525(2). Operated as a third-party administrator without a certificate of authority; issued a misleading statement to the department.	Consent Order $6,500 admin. fine 4/20/05
A-1615 ***Jerome J. O'Connor, Jr.*** Omaha, NE	Violated Neb. Rev. Stat. §§44-1525(11) and 44-4059(1)(b). Violated any insurance law; failed to respond to department within 15 business days.	Order $1,000 admin. fine 6/15/05
A-1617 ***Steve F. Jansen*** Fordyce, NE	Violated Neb. Rev. Stat. §§44-1525(1)(a) & (f) and 44-4059(1)(b),(g) & (h). Misrepresented benefits; misrepresented purpose of inducing policy purchase or cancellation; violated any insurance law; committed unfair trade practice; used fraudulent, coercive or dishonest practices.	Order Producer license previously revoked in A-1605; violations made part of record in the event attempts are made to obtain a license in the future 5/31/05
A-1618 ***Michael Keith Loftis*** Omaha, NE	Violated Neb. Rev. Stat. §§44-4059(1)(b) & (h) and 44-4054(8). Violated any insurance law; demonstrated incompetence or untrustworthiness; failed to notify department of change of address within 30 days.	Order $2,000 admin. fine; producer license suspended until response made and fine is paid 5/25/05
A-1620 ***Jerome J. O'Connor, Jr.*** Omaha, NE	Violated Neb. Rev. Stat. §§44-4059(1)(b) and 44-4065(1). Violated any insurance law; failed to notify department of administrative action taken in another state.	Order Producer license revoked 6/16/05
A-1621 ***Platte Valley Abstract & Title Co. and Joyce A. Low*** Omaha, NE	Violated Neb. Rev. Stat. §§44-4059(1)(h) and 44-19,116(1) (c) & (e). Demonstrated incompetence or untrustworthiness; escrow funds not disbursed pursuant to written instruction; funds disbursed from escrow account prior to receiving and depositing funds in an escrow account.	Consent Order $3,000 admin. fine 6/8/05

Department Calendar

August 27- September 5:	Consumer Information Booth, Devaney Center, Nebraska State Fair
September 5:	Department Closed - Labor Day
October 10:	Department Closed - Columbus Day

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